Montana Medicaid
CLAIM JUMPER

Volume XXII, Issue 2, February 2007

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Private Duty Nursing Provider Rate Increase

The Department increased the reimbursement rate to Private Duty Nursing providers for dates of service beginning January 1, 2007, in accordance with the schedule at the bottom of the page.

The Department increased these rates because our rates have not proven to be as competitive in attracting nursing professionals as we wish them to be. The Department is committed to ensuring there is a well-staffed pool of nurses to deliver care to our clients. We believe that this rate increase will help attain this goal.

Any questions can be directed to Dan Peterson at (406) 444-4144 or to Provider Relations.

Submitted by Dan Peterson, DPHHS

Changes to ASC Payment Rates

The Centers for Medicare and Medicaid Services (CMS) published a revised list of CPT/HCPCS procedure codes and payment rates for Ambulatory Surgical Center (ASC) facilities, effective January 1, 2007. Medicare's ASC payment groups 1-9 determine the amount that Medicare pays for facility services furnished in connection with a covered procedure. Montana Medicaid previously used Medicare rates for groups 1-8 but paid codes not covered by Medicare in an ASC setting at 55 percent of billed charges.

Effective January 1, 2007, Montana Medicaid only pays for services in an ASC setting if the CPT/HCPCS code is on the updated CMS list. Also, codes previously paid by Medicaid at 55 percent of charges are reimbursed using Medicare's payment rate. In other words, Medicaid adopted all of Medicare's methodology for ASC facilities effective January 1, 2007.

The 2007 ASC Approved CPT/HCPCS Codes and Payment Rates can be found at http://www.cms.hhs.gov/ASCPayment.

Questions should be directed to John Hein, Medicaid Program Officer, at (406) 444-4349.

Submitted by John Hein, DPHHS

Provider Reenrollment for NPI

Effective February 1, 2007, providers may begin the reenrollment process by downloading the revised paper enrollment forms, completing them and mailing them to ACS. Reenrollment utilizing the web will be available March 1, 2007. Providers may choose to reenroll using the paper form during February or wait until March to reenroll via the web. However, providers must ensure that reenrollment is completed prior to May 22, 2007, to continue to be reimbursed by Medicaid. Only providers that do not have access to the Internet may use the paper enrollment option after March 1, 2007.

The Department is requiring a reenrollment due to the recommendation

Procedure	Description	Effective	Method	Fee
T1002	RN services up to 15 minutes	01/01/2007	Fee schedule	$7.81
T1003	LPN/LVN services up to 15 minutes	01/01/2007	Fee schedule	$6.59

of the Office of Inspector General since a reenrollment has not been completed since 1997 as well as the implementation of the National Provider Identifier (NPI). During this process, providers will enroll with the NPI numbers they will use beginning May 23, 2007. Prior to May 23, 2007, providers will utilize their proprietary Medicaid and CHIP provider numbers.

Submitted by Michelle Gillespie, DPHHS

Inpatient Out-of-State Hospital Changes

To ensure Medicaid client access to services unavailable in Montana—such as transplants, treatment for cancer, burns, or trauma, or neonatal and pediatric surgical services—the Department has developed two different payment methodologies and new prior authorization requirements for out-of-state inpatient hospital services. Facilities will be designated as either preferred or non-preferred.

These changes were effective for claims with dates of service beginning January 1, 2007. Residential Treatment Facilities are exempt.

Preferred out-of-state hospitals are those located more than 100 miles outside Montana's borders that have signed an agreement with the Department to provide specialized services and have provided a Medicare cost report to the Department. When prior authorization has been obtained, these facilities will be paid by hospital-specific Medicaid inpatient cost-to-charge ratios and cost-settled. Reimbursement without authorization will be at the in-state Diagnosis Related Group (DRG) rate and will not be subject to cost settlement. Acute care psychiatric hospitalizations always require prior authorization.

Non-preferred hospitals—those that do not sign an agreement with the Department—will be treated as Prospective Payment System (PPS) facilities, reimbursed using the in-state DRG methodology, and will not be cost-settled. Services provided by these facilities will no longer require prior authorization except for acute psychiatric hospitalizations and services that normally require prior authorization, such as gastric bypass, transplants, etc.

For assistance in deciding to become a preferred hospital, providers can find the DRG fee schedule at http://medicaidprovider.hhs.mt.gov/providerpages/providertype/01.shtml#feeschedules. Click "Current Fee Schedule" and review the most current version. To review the applicable Montana Administrative Rule (MAR), go to www.dphhs.mt.gov, click on Programs & Services, Legal Resources, and Rule Proposals to find the rule (MAR 37-395 / 11/3/06) on pages 10-11 (37.86.2905).

Providers who want to become a "preferred hospital" should sign the agreement and submit it with their required cost report to:

Mary Patrick, R.N., Hospital Case Manager
Montana Medicaid
P.O. Box 202951
Helena, MT 59620-2951
Fax: (406) 444-1861

If you have trouble accessing the above information or have questions, or for a copy of the "preferred hospital" agreement for review and consideration, please contact Mary Patrick at (406) 444-0061.

New Provider Relations Phone System

Montana's Healthcare Programs Provider Relations Help Line has installed a new phone systsem, and the options have changed. Please listen to the new menu, which enables you to connect to a representative appropriately skilled to answer your question. Also, you will be asked for your provider/submitter number at the beginning of the call to better prepare the call center representative to handle your request.

New menu options include:

- Press 1 for the Eligibility Inquiry menu
- Press 2 for the Provider Inquiry menu
- Press 3 for the EDI menu
- Press 4 for the TPL menu

In addition, the new phone system records all calls for quality assurance. Calls received on the toll-free number are no longer transferrable to other extensions or numbers.

Publications Reminder

It is providers' responsibility to be familiar with Medicaid manuals, fee schedules, and notices for their provider type, as well as other information published in the ***Claim Jumper*** and on the Medicaid website (mtmedicaid.org).

Montana Medicaid Now Covers Birthing Center Services

Montana Medicaid began covering services provided by birthing centers on January 1, 2007.

Birthing centers are freestanding facilities not associated with hospitals. They may bill only for straightforward, uncomplicated vaginal deliveries, with limited revenue and HCPCS codes. They cannot bill for epidurals or surgical procedures.

Birthing center clients have full Medicaid eligibility and, because they are obstetrical clients, they are exempt from PASSPORT and cost-share requirements.

Birthing centers will continue to bill the professional services on a CMS-1500 or 837P using place of service 25. Birthing centers should bill for the facility portion on a UB-92 or 837I, using bill type 841 for services from admit through discharge. Allowed revenue codes include 724 (birthing center for delivery services), 762 (observation) and lab and diagnostics. Only discharge status 01 and 02 are allowed. Providers should continue to submit the pregnancy indicator for electronic claims or the obstetrics indicator on paper claims in order to override PASSPORT and cost share requirements. Newborn assessments are billed with CPT code 99435 and should be billed on the professional claim.

Facilities are reimbursed under the Outpatient Prospective Payment System (OPPS). Any services that do not have an APC, Medicare or Medicaid fee will be set at the statewide outpatient hospital cost-to-charge ratio. Payment for discharge without delivery, such as transfer to another hospital or to home, will be paid like obstetrical observation under the OPPS.

NPI: Get It. Share It. Use It.

Only four months remain until the NPI compliance date. Are you ready to use your NPI?

Enumeration Advice for Incorporated Individual Providers

Health care providers who are individuals are eligible for an Entity Type 1 (Individual) NPI. If these individuals incorporate themselves (i.e., if they form corporations) and the corporations are health care providers, the corporations are organization providers that are eligible for an Entity Type 2 (Organization) NPI. If either of these health care providers (the individual or the corporation) are covered providers (i.e. providers that send electronic transactions) under HIPAA, the NPI Final Rule requires them to obtain NPIs.

NPI Questions

CMS continues to update its Frequently Asked Questions (FAQs) to answer many of the NPI questions they receive on a daily basis. Visit http://www.cms.hhs.gov/NationalProvIdentStand/02_WhatsNew.asp and to go the NPI FAQs link in the Related Links Inside CMS section to view all NPI FAQs.

Providers should remember that the NPI Enumerator can only answer/address the following types of questions/issues:

- Status of an application
- Forgotten/lost NPI
- Lost NPI notification letter (i.e., for those providers enumerated via paper or web-based applications)
- Trouble accessing NPPES
- Forgotten password/user ID
- Need to request a paper application
- Need clarification on information that is to be supplied in the NPI application

Providers needing this type of assistance may contact the enumerator at 1-800-465-3203, TTY 1-800-692-2326, or email the request to the NPI Enumerator at CustomerService@NPIenumerator.com.

Please note: The NPI Enumerator's operation is closed on federal holidays.

Reminder of DME Supplier Enumeration Requirement

As mentioned in the paper entitled, "Medicare Expectations on Determination of Subparts by Medicare Organization Health Care Providers Who Are Covered Entities Under HIPAA," Medicare DME suppliers are required to obtain an NPI for every location. The only exception to this requirement is the situation in which a Medicare DME supplier is a sole proprietor. A sole proprietor is eligible for only one NPI (the individual's NPI) regardless of the number of locations the supplier may have.

Prior Authorization for DMEPOS and Medical/Surgical Procedures Updated Phone and Fax Lines

In preparation for the transition of responsibility for the Prior Authorization of DMEPOS and surgical/medical procedures from the Department to the Mountain Pacific Quality Health Foundation, the Foundation has added separate phone and fax lines to support this function.

As of January 2, 2007, please direct your PA requests to:

Fax: Toll-free local and long distance 1-877-443-2580

Phone: Local (406) 457-5887
Phone: Toll-free long distance 1-877-443-4021, ext. 5887

Please contact Liz Harter, DPHHS SURS/PA Supervisor, at (406) 444-4586 if you have any questions about this transition.

Submitted by Liz Harter, DPHHS

Admit Hour to Be Required for Institutional Claims

Effective March 1, 2007, admit hour (Form Locator 18 on the UB-92 claim form) will be a required field for inpatient and outpatient claims, including crossover claims. This information is necessary to appropriately identify possible duplicate claims.

Provider types affected include inpatient hospital, outpatient hospital, freestanding dialysis clinics, rural health clinics, federally qualified healthcare centers, and Indian Health Services. Home health, hospice and CSHS claims will not require admit hour.

The MMIS will no longer default admit hour to 00. If the provider does not send an admit hour value, the field will remain blank and the claim will be denied.

Please use the following valid values:

Code	Time
00	12:00 midnight – 12:59 a.m.
01	01:00 – 01:59 a.m.
02	02:00 – 02:59 a.m.
03	03:00 – 03:59 a.m.
04	04:00 – 04:59 a.m.
05	05:00 – 05:59 a.m.
06	06:00 – 06:59 a.m.
07	07:00 – 07:59 a.m.
08	08:00 – 08:59 a.m.
09	09:00 – 09:59 a.m.
10	10:00 – 10:59 a.m.
11	11:00 – 11:59 a.m.
12	12:00 noon – 12:59 p.m.
13	01:00 – 01:59 p.m.
14	02:00 – 02:59 p.m.
15	03:00 – 03:59 p.m.
16	04:00 – 04:59 p.m.
17	05:00 – 05:59 p.m.
18	06:00 – 06:59 p.m.
19	07:00 – 07:59 p.m.
20	08:00 – 08:59 p.m.
21	09:00 – 09:59 p.m.
22	10:00 – 10:59 p.m.
23	11:00 – 11:59 p.m.

Please note that an admit hour of 24 will no longer be allowed as it is not a valid value for Montana Medicaid.

Clarification on CPT Codes 36415 and 36416

CPT code 36415 is available for claim submission under Montana Medicaid for routine venipuncture (collection of venous blood), whereas CPT code 36416 is available to describe collection of capillary blood specimens such as finger, heel and ear stick. The provider is responsible for selecting and submitting the code which best describes the service provided (ARM 37.85.413). It is common practice to perform a capillary blood draw to obtain blood specimens on infants, younger children and in some cases, adults. However, on occa-

sion it may be necessary to obtain blood by venipuncture on younger clients. The service provided must be recorded and must support the payment sought for services (ARM 37.85.414). In addition, the Montana Medicaid program shall make payments directly to the individual provider of service. An individual provider may only submit a claim for those services they personally provide (ARM 37.85.406).

Submitted by Kay Propst, DPHHS

Employee Education About False Claims Recovery

The Department received a letter from the Centers for Medicare and Medicaid Services (CMS) offering guidance on the implementation of section 6032 of the Deficit Reduction Act of 2005. This provision establishes section 1902(a)(68) of the Social Security Act which was effective January 1, 2007.

Providers who furnish items or services that Medicaid reimburses at least $5,000,000 annually must comply with the Act. This applies to providers who submit claims for payments using one or more than one provider or tax identification number.

It is the responsibility of providers to create and distribute written policies for their employees, including management, that must also be followed by their contractors or agents. Written policies may be on paper or in electronic form, but must be available to all employees, contractors or agents.

The written policies must include detailed information about the False Claims Act and other conditions named in section 1902(a)(68)(A). The provider shall also include in any employee handbook a specific discussion of the laws described in the written policies, the rights of employees to be protected as whistleblowers and a specific discussion of their policies and procedures for detecting and preventing fraud, waste and abuse.

You may obtain the language included in Public Law 109-171 (section 6032) by going to: www.gpoaccess.gov/plaws/index.html. In the quick search box, type in Public Law 109-171. Scroll down to section 6032 and this will give you the language to be included in the Social Security Act section mentioned above.

SLMB, QI and Medicaid

An MMIS system update was implemented on November 1, 2006, that negatively impacted the processing of SLMB plus Medicaid claims and claims for people who had QI and Medicaid. It has been brought to the Department's attention that CMS guidelines were misinterpreted and these changes resulted in inappropriately denied claims for those clients with SLMB plus Medicaid or QI and Medicaid eligibility.

The Department in conjunction with ACS has developed an action plan to correct this situation. The solution includes short-term changes that will be implemented immediately and long-term permanent changes. Effective December 25, 2006, claims for clients with SLMB plus Medicaid or QI and Medicaid eligibility are suspended and processed for payment, rather than denied. A mass adjustment will be completed for those claims inappropriately denied for dates of payment on or after November 1, 2006.

There is no need for providers to resubmit any claims at this time. We expect the permanent solution to be programmed, tested and implemented in early 2007. Further information related to this situation will be posted on www.mtmedicaid.org or in the *Claim Jumper.*

Montana Medicaid does not cover Medicare coinsurance and deductibles for clients with SLMB or QI eligibility only.

Claims for other dual eligible clients are being processed accurately and no changes are required.

Please accept our apology for the confusion we have caused. Providers may contact Provider Relations with additional questions related to this change.

New 1099 Process

Medicaid providers will see a change in the 1099s received for 2006 reporting Medicaid payments. Effective for calendar year 2006 and forward, ACS will no longer be generating and mailing a separate 1099 for Medicaid payments. The Department of Administration will be combining all payments by tax identification number into one 1099 instead of a separate 1099 for each Medicaid provider number. If you have any questions, please contact Roy Hinman at (406) 444-5932 or Susan Austad (406) 444-4060 at the Department of Public Health and Human Services.

Cost Sharing: When Is It Taken, and How Much Is It?

Cost sharing is the client's financial responsibility for a medical bill as assigned by Medicaid. It is generally taken for services for adults, with a few exceptions. This is usually a flat fee, with the schedule as follows:

Inpatient Hospital
$100 per discharge

Ambulatory Surgery Center, Denturists, DME, FQHC, Freestanding Dialysis Clinics, Outpatient Hospital, RHC, Non-Emergent Care in ER
$5 per visit

Independent Diagnostic Testing Facility, Mid-level Practitioners, Physicians, Podiatry, Psychiatrists
$4 per visit

Dental, Home Health, LCPCs, Psychological Services, Social Worker, Speech Therapy
$3 per visit

Audiology, Hearing Aids, Occupational Therapy, Opticians, Optometric, Physical Therapy
$2 per visit

Public Health Clinics
$1 per visit

Pharmacy
$1-$5 per script
$25 monthly cap

Clients who reside in a nursing home or receive hospice, personal assistance, or home and community based services do not have cost share taken for any services. Pregnant women will not have cost share taken if providers use an appropriate EPSDT code, which indicates pregnancy. This indicator can only be used on females and should only be used when the female is pregnant, through the covered post-partum period (which begins when the pregnancy ends and

extends through the end of the month in which 60 days have passed).

If a client has TPL or Medicare, cost sharing may or may not be assessed. If the TPL or Medicare pays on the claim, no cost share will be taken. However, if the claim is denied by TPL or by Medicare, the client will still be responsible for that cost share amount. This includes situations where the claim is applied to the deductible.

If you have any questions on cost sharing you can contact Provider Relations at 800-624-3958 or 406-442-1837.

New Place of Service

Claims may now be submitted using place of service "01" (pharmacy). This place of service is now valid in the MMIS.

14,250 copies of this newsletter were printed at an estimated cost of $.47 per copy, for a total cost of $6,736.49, which includes $3,758.56 for printing and $2,977.93 for distribution.

Alternative accessible formats are available by calling the DPHHS Office of Planning, Coordination and Analysis, at (406) 444-9772.

Recent Publications

The following are brief summaries of recently published Medicaid information and updates. For details and further instructions, download the complete document from www.mtmedicaid.org, the Provider Information website. Select ***Resources by Provider Type*** for a list of resources specific to your provider type. If you cannot access the information, contact Provider Relations at (800) 624-3958 or (406) 442-1837 in Helena or out-of-state.

Recent Publications Available on Website

Date	Provider Type	Description
Notices		
12/08/06	Ambulatory Surgical Centers	Changes to ASC Payment Rates
12/22/06	DMEPOS, Physicians, Mid-Level Practitioners, Lab and X-ray, Podiatrists, IDTF, Public Health Clinics, Speech Therapists, Physical Therapists, Occupational Therapists	Prior Authorization for DMEPOS and Medical/ Surgical Procedures Updated Phone and Fax Lines
12/26/06	Private Duty Nursing	Provider Rate Increase
Other Resources		
12/04/06, 12/11/06, 12/18/06, 12/26/06	All Provider Types	What's New on the Site This Week
12/04/06	All Provider Types	News item regarding delay of e!SOR and 835 files removed from home page
12/07/06	Pharmacy	December 2006 DUR meeting agenda
12/13/06, 12/14/06	All Provider Types	January 2007 *Claim Jumper*
12/13/06	All Provider Types	Link to the National Guideline Clearinghouse™ added to Web Links page
12/13/06	All Provider Types	News item regarding corrected RAs available on web portal added to home page
12/14/06	All Provider Types	News item regarding new 1099 process added to home page
12/14/06	All Provider Types	Updated remittance advice notice
12/19/06	All Provider Types	News item regarding delay of e!SOR and 835 files added to home page
12/19/06	All Provider Types	Revised paperwork attachment cover sheet added to Forms page
12/22/06	All Provider Types	News item regarding SLMB, QI and Medicaid added to home page

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U.S. Postage
PAID
Great Falls, MT
Permit No. 151

Key Contacts

Provider Information website: http://www.mtmedicaid.org
ACS EDI Gateway website: http://www.acs-gcro.com
ACS EDI Help Desk (800) 624-3958
Provider Relations
(800) 624-3958 (In and out-of-state)
(406) 442-1837 (Helena)
(406) 442-4402 Fax
Email: MTPRHelpdesk@ACS-inc.com
TPL (800) 624-3958 (In and out-of-state)
(406) 443-1365 (Helena)
(406) 442-0357 Fax
Direct Deposit Arrangements (406) 444-5283
Verify Client Eligibility
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
Point-of-Sale Help Desk for Pharmacy Claims (800) 365-4944
PASSPORT (800) 362-8312
Prior Authorization
Mountain-Pacific Quality Health Foundation (800) 262-1545
Mountain-Pacific Quality Health Foundation—DMEPOS/Medical
(406) 457-5887 local, (877) 443-4021, ext. 5887 long-distance
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

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P.O. Box 4936
Helena, MT 59604

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